STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00180481, IN00181352, and IN00181438. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification, State Licensure Survey and Investigation of Complaints IN00176650 and IN00175716, completed on August 7, 2015. This visit was in conjunction with a PSR to the Investigation of Complaint IN00179129, completed on August 7, 2015. Complaint IN00180481- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00181352- Unsubstantiated due to lack of evidence. Complaint IN00181438- Unsubstantiated due to lack of evidence. Survey dates: September 17, 18, 21, and 22, 2015 Facility number: 012466 Provider number: 155786 AIM number: 201014060 Census bed type: SNF: 19 SNF/NF: 115 Total: 134 Census payor type: Medicare: 19 Medicaid: 92	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	**10312 ALLISONVILLE RD FISHERS, IN 46038**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Other: 23 Total: 134 Sample: 3 Allisonville Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00180481, IN00181352, and IN00181438. Quality review completed by 30576 on September 25, 2015.	F 000		